

“House Hearing Addresses Coordinating HIT Funding and Programs,” HIMSS Advocacy News, November 8, 2007

Advocacy News

HOUSE HEARING ADDRESSES COORDINATING HIT FUNDING AND PROGRAMS

WASHINGTON, D.C. (November 8, 2007) -- The House Committee on Oversight and Government Reform Subcommittee on Government Management, Organization, and Procurement convened a hearing on coordinating federal and state health IT on last Thursday. Chairman Edolphus Towns (D-NY) opened the hearing by expressing his concern about developing top-down solutions and not fully connecting them to the reduction of health disparities in the communities that need them the most. He also explained his concern about the programs that state and local governments have started will ultimately be bypassed by one-size federal solution.

Dr. Robert Kolodner, the National Coordinator, Office of the National Coordinator for Health IT (ONC) explained ONC's vision for interoperable health IT and how his office is working with agencies and stakeholders to meet the needs of our nation's medically underserved. He stated that specific requirements are included in the Nationwide Health Information Network (NHIN) trial implementation contracts to work with providers that serve medically underserved populations. The inclusion of safety net providers who serve low-income and other vulnerable populations can help ensure that the medically underserved community benefits from interoperable health information exchange throughout the country.

Dr. Kolodner was followed by Cheryl Austein Casnoff, M.P.H, Associate Administrator, Office of Health Information Technology, Health Resources and Service Administration who stated that HRSA's Office of Health Information Technology (OHIT) promotes the adoption and effective use of HIT in the safety net community. OHIT's goal is to bring HIT to America's safety net providers; in particular HRSA grantees, to improve quality of care, reduce health disparities, increase efficiency in care delivery systems, increase patient safety, decrease medical errors prevent a digital divide and allow providers to improve quality and efficiency of the care they provide.

The first panel concluded with testimony from Dr. Carolyn M. Clancy, Director, Agency for Healthcare Research and Quality (AHRQ). Dr. Clancy testified that AHRQ work closely with the Office of the National Coordinator of Health IT and other Federal agencies to assure that the agency's investment are closely aligned and concentrated on the use of health information technology to improve safety and quality in diverse health care settings with a strong focus on those organizations providing care to underserved and rural populations. Congressman Towns also asked the first panel what they would do to make sure that underserved communities are not neglected. Casnoff addressed this question by saying that HRSA's mission is geared toward addressing the needs of underserved communities. And that HIT is a tool to help move that agenda forward. HRSA Grants are specifically designed to accelerate the pace of quality care in the underserved communities. Dr. Kolodnar stated that we need to make sure in every aspect that are looked at that the the medically underserved communities and those who serve them are involved. Dr. Clancy said that it is not a given that we have to have a digital divide and we can't bring every along together. The collective challenge would be to scale this up as rapidly as possible.

The second panel was highlighted by the testimony of Dr. Neil S. Calman, President and CEO, The Institute for Family Health. Dr. Calman testified at the behest of HIMSS. Dr. Calman made the following recommendations to assist the legislature in maximizing the opportunities that health

information technology will provide to help reduce disparities in health care practices and health outcomes for people of color.

1. Insure that all legislation that supports the implementation of electronic health records targets those patients at highest risk on our society.
2. Insure that all legislation that supports health information exchange (HIE) includes provisions that safety-net providers-specifically community health centers and public hospitals-must be included in HIE networks.
3. Fund the integration of all EHRs, especially those in safety net facilities, into local regional and state health department systems that monitor the disease burden in the community and help people optimize their preventive health care measures.
4. Mandate that all HER systems capture data on race, ethnicity, gender and primary language so that providers can examine disparities that exist in treatment within their systems and address them through targeted efforts aimed at high risk populations.
5. Encourage EHR vendors to provide a mechanism for alerting providers to clinical trials which may be relevant to their patients. People of color are underrepresented in many clinical trials in this country and EHRs provide an easy way to identify patients who meet clinical trial criteria so that they may be offered the opportunity to participate. This improves the relevance of clinical findings of these studies to ethnically diverse populations.
6. Create criteria for EHR certification that require that information produced for patient consumption, such as health education materials, visit summaries, portals that allow patients internet access to their own health information-all be made available in multiple languages and at a 4th grade literacy level when needed.
7. Insure that rural areas are funded to deploy broadband technology and that broadband access is provided in all public housing being built. A timetable should be set to retrofit all existing public housing facilities with broadband capability.
8. Require the input of communities of color in planning privacy and security requirements for health information exchange, and in developing consent procedures for participation in health information exchange. There are well documented, legitimate reasons that issues of privacy, security and consent procedures will play out differently in communities of color. It must be re-established that information provided by patients and entered in their electronic health records, as well information shared in health information exchange networks, is not subject to government use for purposes of identifying undocumented immigrants.
9. Provide resources for health information technology adoption in prisons, in the foster care system, for homeless health care providers, for migrant health care providers serving vulnerable populations, so that these mobile and transient patients can have records that are available wherever they go for care.
10. Create a national system for specifically monitoring the impact of health information technology and health information exchange efforts on vulnerable populations, and tie future funding to successes in eliminating disparities in participation in these efforts and ultimately in the care improvements which results.

Other key testimonies came from Dr. Winston Price, past President of the National Medical Association (NMA) and current Chair of the Georgia Health Information Technology & Transparency Board, Dr. Farzad Mostahari, Assistant Commissioner, Primary Care Information Project New York City Department of Health and Mental Hygiene and Lori Evans, Deputy Commissioner, New York State Department of Health, Office of Health Information Technology Transformation.